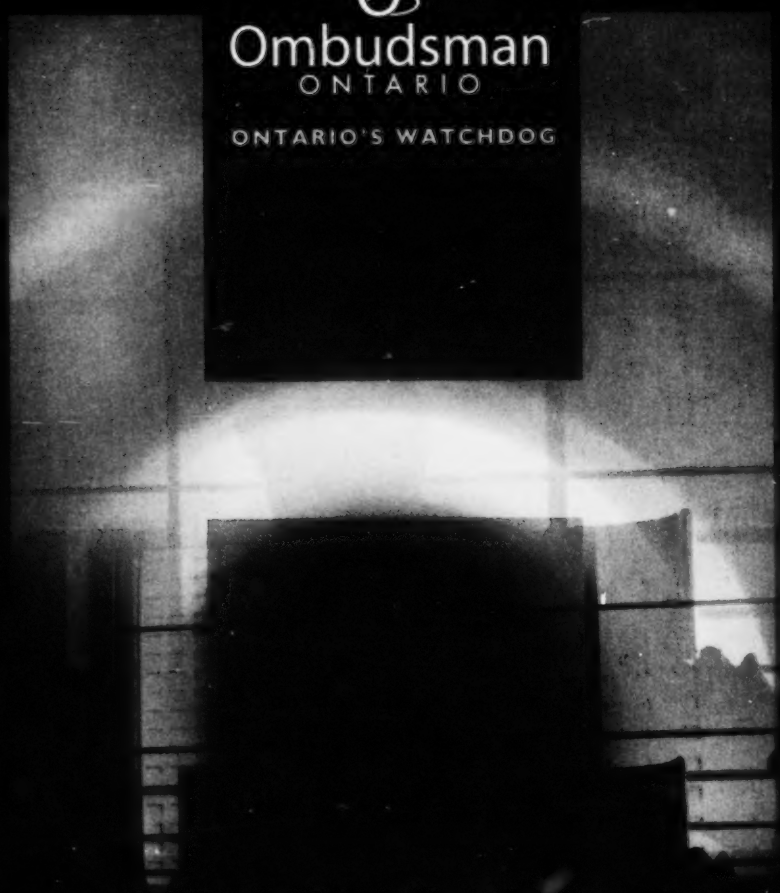

The LHIN Spin

Investigation into the Hamilton Niagara Haldimand Brant Local Health Integration Network's use of community engagement in its decision-making process.

OMBUDSMAN REPORT

André Marin, Ombudsman of Ontario • August 2010

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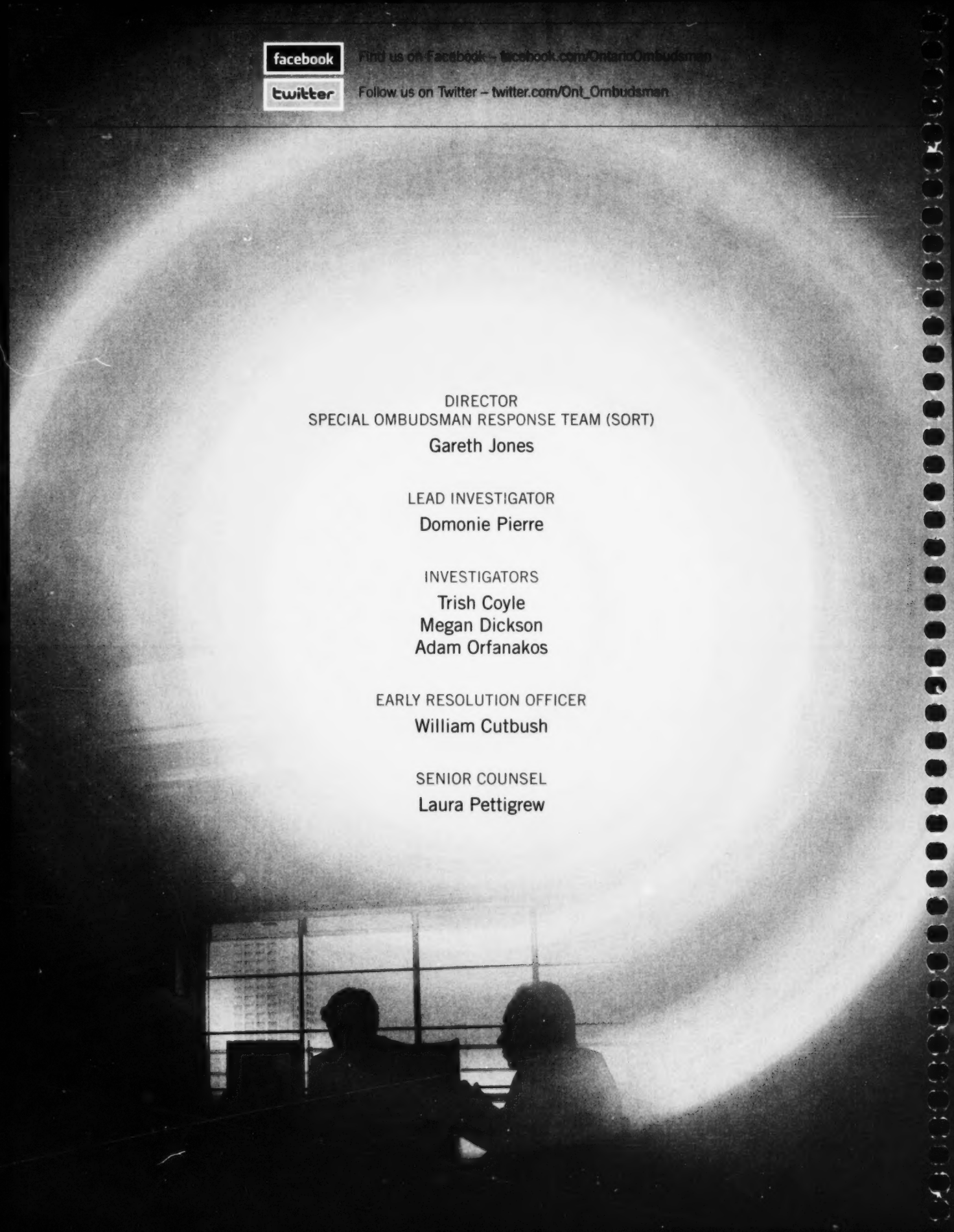

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Ombudsman Report

Investigation into the Hamilton Niagara Haldimand Brant Local Health Integration Network's use of community engagement in its decision-making process

"The LHIN Spin"

André Marin
Ombudsman of Ontario
August 2010

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Overview

1 Government officials touted the arrival of the Local Health Integration Networks as heralding a new era in community health care. Citizens, health service providers and other stakeholders were repeatedly told by government representatives that under the LHIN system, they would have a voice in the health services decisions that affected them. The public was assured that with the advent of the LHINs, an aloof, centralized bureaucracy would no longer be making significant decisions about the future of community health services. Instead, decisions would be informed by local needs and priorities, and made in and by the community for the community.

2 Unfortunately, while it is true that as a result of the LHIN model, the Ministry of Health and Long-Term Care has been able to distance itself from difficult decisions surrounding the integration and funding of regional health services, the reality of community decision-making has fallen far short of the political spin.

3 While members of the 14 LHIN boards of directors are selected from their communities, the extent to which the broader public is actually engaged in decision-making remains undefined and inconsistent. The *Local Health System Integration Act, 2006* provides limited direction when it comes to community engagement. There are no clear minimum standards for soliciting community views on systemic priorities or specific integration plans, and different LHINs interpret their public outreach obligations differently. Understandably, this has led to considerable confusion about the nature of community engagement carried out by both health service providers and the LHINs. This has engendered growing public frustration with LHIN decisions in some areas.

4 My Office received more than **60** complaints about two controversial local health services restructuring plans affecting residents in the Hamilton Niagara Haldimand Brant region: The Hamilton Health Sciences "Access to Best Care Plan" and the Niagara Health System "Hospital Improvement Plan."

5 The Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) has taken steps to obtain local stakeholder views on the general state of the health care system in its region, which it has used to inform its long-term strategic vision for health services. However, when it comes to concrete planning relating to individual restructuring plans, which promise to have direct and immediate impact on the lives of local residents, many citizens have been highly critical of the adequacy of community engagement. One of the core problems we identified was that the LHIN had not educated the public about what to expect in the way of community engagement through health service providers and its own processes.

6 The HNHB LHIN, like its counterparts throughout the province, is charged with making tough decisions. Inevitably, the LHIN will never please all stakeholders – that is why it is critical that LHINs operate as transparently as possible. Under the *Local Health Services*

Integration Act, LHINs in Ontario are required to hold meetings that are open to the public, subject to a limited number of prescribed exceptions. However, similar to other LHINs, the Hamilton Niagara Haldimand Brant LHIN has adopted a template by-law which purports to permit its board of directors to meet behind closed doors for "education sessions." The LHIN followed this practice when considering the two restructuring plans, which led to complaints to my Office.

7 Unfortunately, this practice is antithetical to the LHIN model. It serves to undermine the integrity and credibility of the LHIN's decision-making, and in my view, is simply illegal. Any possible advantage gained by the board in meeting in private is inevitably lost by the risk of inciting public suspicion around unpopular decisions.

8 The LHIN model may represent an evolution in local health services planning, but it is not without its growing pains. Community engagement is fundamental to the success of the LHIN model, and my investigation has revealed that, at least in the case of the HNHB LHIN, community engagement has not lived up to its promise. Accordingly, in this report I am making three recommendations addressed at improving the situation. First, in order to inject greater accountability and consistency into the LHIN decision-making process generally, I am recommending that the Ministry of Health and Long-Term Care consider putting forward guidelines setting out minimum standards relating to community engagement to be undertaken by both health service providers and LHINs. Second, I am recommending that the HNHB LHIN educate the public using its website, meetings and other methods concerning its general practices relating to community engagement as well as the nature of community engagement to be expected with respect to specific plans under consideration. And finally, I am recommending that the LHIN amend its By-law 2 and immediately cease its practice of holding closed educational sessions or other private meetings in contravention of the Act. In addition, I have recommended that both the Ministry and the HNHB LHIN report back to me on their progress in implementing my recommendations.

9 The Ministry has signalled a willingness to take steps to enhance the openness and transparency of the LHIN decision-making process, and has undertaken initiatives recently to address community education guidelines. However, despite its lip service to the principle of transparency, the Ministry is not fully committed to openness with respect to the LHIN process. In initially responding to my recommendations, the Ministry did not take issue with my conclusion that the open meeting requirements of the *Local Health System Integration Act, 2006* prevent LHINs from holding closed and unannounced meetings during which information is obtained and discussed relevant to their decision-making. However, the Ministry recently flip-flopped, taking the position that all LHINs are free to hold "education" meetings that are closed to the public provided no actual decisions are reached during these secret sessions. The Ministry's attempt to justify this clandestine practice is very disturbing and clearly inconsistent with the plain wording of the legislation. Unfortunately, the Ministry's stance allows for the perpetuation of the air of mystery that we found surrounded the HNHB LHIN's decision-making. In my view, it

is antithetical to the community engagement principles in the Act, wrong in law, and does not serve the public of Ontario well. I note that the Deputy Minister wrote in his July 15, 2010 letter to my Office that "the Ministry is continuing to review the situation with respect to your concerns related to educational meetings" and that the Ministry "will be taking action to clarify educational meetings and enhance the already extensive regulatory framework designed to foster openness and transparency." I sincerely hope that the Ministry will ultimately reconsider its position regarding the application of the open meeting requirement.

10 As for the HNHB LHIN, it did not accept my findings and opinions concerning its role with respect to community engagement and the legal requirement to hold public meetings. The HNHB LHIN also did not commit to take any action in response to my recommendations. While recently the LHIN has taken some steps towards greater transparency concerning community engagement, its attitude, combined with its failure to follow an open and transparent process, threatens to erode public confidence in decision-making relating to the local health system.

Investigative Process

11 On September 5, 2008, our Office received a complaint from a resident of the Niagara region about the lack of public consultation undertaken by the HNHB LHIN regarding the proposed restructuring of the Niagara Health System. Soon after, we received a complaint from Hamilton Centre NDP MPP Andrea Horwath that the same LHIN had failed to comply with its community engagement obligation in connection with its decision on a voluntary integration plan proposed by Hamilton Health Sciences. As we were reviewing these complaints, we received 38 more about the LHIN's community engagement when deciding on restructuring plans.

12 The complaints focused on the Hamilton Health Sciences "Access to Best Care Plan," and the Niagara Health System "Hospital Improvement Plan."

13 While I received complaints about the content of the plans and the adequacy of the community engagement undertaken by the involved health service providers, I have no authority to consider these matters, as hospitals do not come within my jurisdiction. The LHIN, however, is a provincial governmental organization coming within my mandate, and the issue of the sufficiency of the community engagement it undertook when arriving at its decisions is something that I can address.

14 On March 24, 2009, I advised the Ministry of Health and Long-Term Care and the HNHB LHIN of my intention to investigate. After the investigation was publicly announced, we received another 26 complaints from municipal leaders, health care professionals,

community associations and individual residents, all of whom highlighted community engagement as a key concern.

15 A Special Ombudsman Response Team (SORT) of four investigators and an Early Resolution Officer was assigned to conduct the investigation. The team conducted 51 interviews, including with all eight members of the LHIN board, as well as a number of LHIN staff.

16 In-depth interviews were also conducted with 33 complainants, municipal leaders, health care professionals, community associations and residents, as well as senior representatives from other LHINs, and government health officials in other jurisdictions. Investigators also interviewed officials from the Ontario Ministry of Health and Long-Term Care LHIN Liaison Branch, the Ontario Medical Association and the Ontario Hospital Association. Most interviews were tape-recorded and transcribed.

17 The team also reviewed extensive documentation, including 35 binders of documents received from the HNHB LHIN, as well as documents received from the Ministry of Health and Long-Term Care. The SORT team received excellent co-operation from both the LHIN and the Ministry.

Evolution by Devolution: The LHINs Emerge

18 Historically, health services in Ontario were funded through the Ministry of Health and Long-Term Care, which dealt directly with hundreds of health service providers in communities throughout the province. In September 2004, the then Minister of Health and Long-Term Care, George Smitherman, announced that the government would be launching a new local and integrated approach to the funding of health services in Ontario, through the creation of 14 Local Health Integration Networks, or LHINs.

19 While the Ministry would retain an overarching strategic stewardship role, the LHINs would be delegated authority to make decisions affecting the funding and delivery of local health services. Once the LHINs were operational, responsibility for approximately $20 billion, which in 2004 represented two-thirds of Ontario's health care budget, would devolve to the local level.[1]

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[1] Health care spending has since increased to the point where it now represents about 46 cents out of every dollar of Ontario government program spending. The Ministry of Health and Long-Term Care's budget is estimated at more than $44.4 billion for the 2010-2011 fiscal year, with more than $21.5 billion going to the LHINs and related health service providers, representing just under 50% of the Ministry's overall spending.

(Ontario Ministry of Finance, 2010 Ontario Budget, Sector Highlights, Health <http://www.fin.gov.on.ca/en/budget/ontariobudgets/2010/sectors/health.html> (last accessed 24 June 2010); and

20 The LHINs were touted as "the next evolution of health care in Ontario … a made-in-Ontario solution."[2] The basic premise underlying the LHIN model is that a community's health care should reflect community needs, and be planned, co-ordinated and funded in an integrated manner within and by local communities.

21 While the legislation that would bring the LHIN system into being was still in the drafting stages, the Ministry began to work on establishing the LHIN infrastructure. During November and December 2004, the Ministry's System Integration Team conducted a series of workshops in the 14 communities in Ontario that would eventually form the geographic boundaries for the LHINs. The team met with about 4,000 people, including citizens, health service providers, and community and patient advocacy organizations. As a result of these workshops, the Ministry identified existing and future integration priorities for the various communities. The team submitted 14 integration priority reports to the Ministry in February 2005.

22 In June 2005, the Ministry began setting up 14 non-profit corporations, which would become the future LHINs.

23 While development of the LHINs proceeded, Bill 36, the *Local Health System Integration Act, 2005*, was introduced in the Legislature in November 2005. By March 28, 2006, the Act had received royal assent. Under the Act, the LHINs are responsible for planning, integrating and funding the health care system in each of 14 geographic areas designated by the Ministry. The 14 corporations established before the Act came into force became the LHINs upon its enactment. The Ministry provided the chair of each LHIN with the integration priority reports to inform their integrated health services plans.

24 The LHINs were gradually provided with their statutory authority, receiving full funding responsibility on April 1, 2007. Since that date, instead of the Ministry paying hospitals, community care access centres and other health service providers directly, the Ministry has provided funding to the LHINs for distribution. The Ministry and each LHIN must enter into an accountability agreement that includes specific goals and objectives. In turn, each LHIN enters into a service accountability agreement with each health service provider that it funds, which sets out the obligations and expected outcomes for health delivery services. Every three years, each LHIN must develop an integrated health services plan, setting out priorities for its community.

Ontario Ministry of Finance, Expenditure Estimates, 2010-2011, Vol. 1 (April 22, 2010) Health and Long-Term Care <http://www.fin.gov.on.ca/en/budget/estimates/2010-11/volume1/MOHLTC.html> (last accessed 24 June 2010).

[2] Ontario, Health Results Team, Ministry of Health and Long-Term Care, *Health Results Team First Annual Report 2004-05* (Toronto: Queen's Printer, 2005) at 4.

25 One of the purposes behind the LHIN approach was to eliminate unnecessary duplication in the provision of health services and better co-ordinate services within the community. To that end, each LHIN and health service provider is required – separately and in conjunction – to identify opportunities to integrate the services of the local health system to provide appropriate, co-ordinated, effective and efficient services. [3]

26 The LHINs are Crown agents, governed by boards of directors appointed by the provincial Cabinet and approved by the Lieutenant Governor. The government has indicated that LHIN directors are selected from the communities that the LHINs are intended to serve. To qualify for part-time positions on a LHIN board, appointees must have a background in health care, public administration, management, accounting, finance, law, human resources, labour relations, communications, or information management. Each LHIN also has a salaried chief executive officer and may hire additional staff.

27 While the *Local Health System Integration Act* was being considered in the Legislature, rather lofty statements were made about the LHIN model and its emphasis on engaging the community in local decision-making. For instance, the then Minister of Health and Long-Term Care, Mr. Smitherman, reinforced community involvement in LHIN decision-making on several occasions. In November 2005, he said:

> Local health integration networks will also have a duty, I daresay an obligation, to consult with communities about the decisions that are before them. This legislation makes it very clear that decisions must be made on the basis of public interest and in the full view of the public.[4]

28 In April 2006, he said:

> Community involvement stands very strong. We believe fundamentally that the health care system which belongs to the people of Ontario needs to come under more of their influence. We need to open up their opportunities to influence it and offer their views on how it can be enhanced.[5]

29 Consistent with the LHIN model's emphasis on local decision-making, the Act expressly refers to "community engagement."

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[3] *Local Health System Integration Act, 2006*, S.O. 2006, c. 4, s. 24 [*Local Health System Integration Act*].

[4] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, (24 November 2005) at 1400 (Hon. George Smitherman).

[5] Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, (6 April 2006) at 1510 (Hon. George Smitherman).

Defining Community Engagement

30 The Act provides that one of the objects of the LHINs is to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation. [6]

31 In addition, each LHIN is expressly required "to engage the community of diverse persons and entities involved with the local health system about that system on an ongoing basis, including about the integrated health service plan and while setting priorities."[7]

32 "Community engagement" is not defined in the Act, but it does specify that "community" includes patients and other individuals in the geographic area of the network, health service providers and any other person or entity that provides services in or for the local health system and employees involved in the local health system. [8] The Act also indicates that the methods for carrying out community engagement may include holding community meetings or focus group meetings or establishing advisory committees.[9] Community engagement must also include prescribed aboriginal, First Nations and French-language health planning entities.[10] In addition, the LHINs are required to establish a health professionals advisory committee. [11]

33 While each LHIN is responsible for community engagement in system planning, each health service provider is required "to engage the community of diverse persons and entities in the area where it provides services when developing plans and setting priorities for the delivery of health services."[12] This obligation is reinforced in the service accountability agreements entered into between LHINs and health service providers.

34 The Act provides that the province may make regulations respecting community engagement including how and with whom a LHIN or a health service provider shall engage the community, the matters about which a LHIN or a health service provider must

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[6] *Local Health System Integration Act*, *supra* note 3, s. 5(c).

[7] *Ibid.*, s. 16(1).

[8] *Ibid.*, s. 16(2).

[9] *Ibid.*, s. 16(3).

[10] *Ibid.*, s. 16(4).

[11] *Ibid.*, s. 16(5).

[12] *Ibid.*, s. 16(6).

engage the community, and the frequency of the engagement.[13] However, no regulations further refining the community engagement obligation have been issued.

35 In addition, the Act provides that when a LHIN requires a health service provider to proceed with an integration of health services or orders a health service provider not to proceed with a voluntary integration of services, the public is entitled to notice of the proposed decision and 30 days to make written submissions in response.[14] The Act also underscores the transparency of the LHINs' decision-making process by requiring that all the meetings of the LHIN boards are to be open to the public, subject to a limited number of specific exceptions.[15] The public may **only** be excluded if:

(a) financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public;

(b) matters of public security will be discussed;

(c) the security of the members or property of the network will be discussed;

(d) personal health information, as defined in section 4 of the *Personal Health Information Protection Act, 2004*, will be discussed;

(e) a person involved in a civil or criminal proceeding may be prejudiced;

(f) the safety of a person may be jeopardized;

(g) personnel matters involving an identifiable individual, including an employee of the network, will be discussed;

(h) negotiations or anticipated negotiations between the network and a person, bargaining agent or party to a proceeding or an anticipated proceeding relating to labour relations or a person's employment by the network will be discussed;

(i) litigation or contemplated litigation affecting the network will be discussed, or any legal advice provided to the network will be discussed, or any other matter subject to solicitor-client privilege will be discussed;

(j) matters prescribed for the purposes of this clause will be discussed; or

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[13] *Ibid.*, s. 37(1)(f).

[14] *Ibid.*, ss. 26 and 27.

[15] *Ibid.*, s. 9.

(k) the network will deliberate whether to exclude the public from a meeting, and the deliberation will consider whether one or more of clauses (a) through (j) are applicable to the meeting or part of the meeting.

36 The LHIN board must deliberate and vote publicly about whether to exclude the public from a meeting, based on the permitted exceptions. A motion to exclude the public must also clearly state the nature of the matter to be considered at the closed meeting and the general reasons why the public is being excluded.

37 The degree of community engagement that a LHIN is required to undertake was the subject of a 2008 court challenge. In *Ontario Public Service Employees Union* v. *Central East Local Health Integration Network,*[16] the Ontario Superior Court of Justice considered whether the Central East LHIN should have engaged in public consultation with respect to the Rouge Valley Health System's deficit elimination plan, which called for the consolidation of mental health services within the two sites it operated. After reviewing the plan, the Central East LHIN had agreed to enter into a revised service accountability agreement with the service provider. It had also required that the service provider conduct public consultation prior to implementing its plan. The court rejected arguments that the LHIN should have consulted with the public in these circumstances. The court found that the situation did not trigger the requirement to provide formal notice to the public and an opportunity to make written submissions. In addition, the court noted that the general obligation of the LHIN to engage the community about the "system" had been satisfied when the Central East LHIN developed its integrated health service plan. The court observed that:

> … general statements about the importance of community engagement, particularly in the setting of priorities and development of an HSP [health services plan], are not sufficient to give rise to an enforceable right to consultation about LHIN funding decisions.

38 A concern had also been raised in that case that the LHIN had improperly held *in camera* meetings. The Court did not address this issue, since no decisions had been made at the closed sessions and no claim for relief turned on it.

39 At present, "community engagement" is a rather nebulous concept, which individual LHINs are left to interpret and apply, based on assessments of their local community needs. It has been noted that despite the requirement for LHINs to engage the community, there is "very little specificity in the legislation about how [community engagement] should be carried out, with whom and through what methods." And as a result, "LHINs have largely been left on their own to develop their own [community engagement]

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[16] 2008 CanLII 41820 (Ont. Div. Ct).

plans."[17] An official at the Ministry's LHIN Liaison Branch suggested to us that this legislative imprecision was deliberate and intended to allow the various LHINs flexibility in meeting their mandate. During our investigation, many of the representatives from LHINs throughout Ontario expressed the view that this aspect of the community engagement provisions was a positive factor that permitted engagement to be adapted to suit local needs. On the other hand, some community members were quite critical of the uncertainty that this approach engendered and suggested that there should be clearer legislative parameters.

40 It is possible that over time more consistency might develop with respect to the nature of community engagement conducted in Ontario. In March 2009, the 14 LHINs collaborated with an independent health policy organization to mount a symposium and workshop "Community Engagement & the LHINs: Truths and Consequences."[18] The participants shared their experiences, perspectives and understanding about the importance, opportunities and challenges of community engagement faced by the LHINs. In June 2009, the web resource "Engaging People, Improving Care (EPIC)," was made available to the LHINs and public as a result of the collaboration of the Ontario Hospital Association, health service provider associations and LHINs. It includes best practices relating to community engagement.[19]

41 At present, there is no mandatory minimum standard that must be met to satisfy a LHIN's public outreach obligation. This gap continues to leave open the possibility that citizens in different regions of the province will experience a considerable variance in the quality and quantity of community engagement.

42 Certainly, many of the people who complained to our Office about the Hamilton Niagara Haldimand Brant Local Health Integration Network suggested that they would have benefited from greater guidance or information concerning what to expect from community engagement.

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[17] *Community Engagement & the LHINs: Truths and Consequences*, Symposium and Workshop Summary Report March 11, 2009; pg. 16

[18] This symposium and workshop was held on March 11, 2009. It was a collaboration between Ontario's 14 LHINs and The Change Foundation.

[19] The HNHB LHIN's website includes this link to EPIC: http://www.epicontario.ca/Home.aspx .

The HNHB LHIN is Born

43 The Hamilton Niagara Haldimand Brant LHIN was first introduced to its community in June 2005. It covers an area of approximately 7,000 square kilometres and includes the City of Burlington and much of Norfolk County. There are approximately 250 health service providers within its boundaries and 1.4 million Ontarians, making it the second-largest LHIN in the province, per capita. Currently, the LHIN has an annual budget of approximately $2.2 billion, of which $5 million is used to operate the LHIN[20] and the rest earmarked for transfer to health service providers.

44 The LHIN has eight part-time directors, as well as a Chief Executive Officer and 31 staff positions. It is based in Grimsby.

45 The LHIN board is responsible for decision-making with regard to health services planning, integration and funding within its region. The board meets once per month in open session. It also holds closed "education" sessions, during which it obtains additional information on specific plans and issues that are before it or that it would like to learn more about. By-Law No. 2 states that a board meeting "for social, educational or purposes other than conducting Corporation business is not a Board Meeting." The LHIN's By-law 2 is based on a template that has apparently been adopted by LHINs throughout the province. During its private "education" sessions, the LHIN board meets with groups or persons it believes will help it reach a better understanding of the issues before it. However, all decisions are made in open session.

46 The HNHB LHIN made its public debut in June 2005 at a media event at a seniors' centre in Grimsby. Shortly thereafter, it began the process of engaging the community concerning issues relating to health services.

The Community Gets Engaged

47 During July and August 2005, the HNHB LHIN held introductory meetings with health service providers, including their governors, to introduce the LHIN model and inaugural LHIN leadership teams. These meetings were by invitation only. Open houses for the general public were hosted by the LHIN Board Nominating Committee in September and October 2005 to introduce the LHIN model and recruit interested applicants for the LHIN Board. The LHIN was also busy during the fall and winter of 2005, recruiting staff, and conducting various information sessions with community stakeholders. At its open houses and sessions, the LHIN also solicited attendees' views on health care in the community.

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[20] The LHIN uses these funds to support its planning, funding and integration roles, including community engagement. While the April 1, 2007 – March 31, 2010 Accountability Agreement with the Ministry refers to $4.028 million being allocated for this purpose, the LHIN advised that $5 million is actually used to operate the LHIN.

48 In March 2006, the LHIN issued a document relating to community engagement, entitled *Our Commitment to you: Community Engagement for Health Care Planning & Decision Making*, in which it described community engagement as one of its core functions. The document also refers to different levels of engagement, ranging from "informing" to help the public understand issues, "consulting" to solicit feedback, "involving" the public to ensure that public and private concerns are considered and understood, "collaborating" on each aspect of the decision-making, to "empowering," where decision-making is actually placed in the hands of the public.

49 In developing its first integrated health services plan, the LHIN was guided by the information provided by the Ministry's System Integration Team concerning the priorities it had identified through its community workshops in the fall of 2004. In addition to its earlier open houses, meetings and information sessions, the LHIN held 14 open houses throughout the community, where it discussed the priorities that had been identified and received stakeholder views. Community comments were taken into consideration when the LHIN prepared its draft Integrated Health Services Plan, which was released to the public for comment through six open houses held in early fall 2006. The final plan was published in November 2006. Integrated Health Services Plans are required to be submitted every three years. The LHIN held community open houses in the fall of 2009 that focused on finalizing its plan for the next three years. The HNHB LHIN's 2010-2013 Integrated Health Service Plan was issued in December 2009.

50 During our investigation, the LHIN advised that as part of its ongoing community engagement, it periodically meets with MPPs and mayors in its catchment area, editorial boards of local newspapers and other stakeholders. The LHIN attends various meetings with community groups, the public and health service providers regarding the community health care system generally as well as specific initiatives. It has indicated that all of these contacts serve to inform its vision of providing the "right care, at the right place, at the right time for community members." LHIN officials suggested that community engagement is an ongoing cumulative process – "a journey, not just an event." We also heard that "community engagement" was a very fluid concept, and could consist of an informal phone call or even a casual conversation with someone in the community. Those "being engaged" might not even be aware that their comments are being filed away for later use in determining priorities and planning for local health services.

51 Citizens can contact the LHIN in writing, by telephone, through its website, or through a request for a speaker. The LHIN board does not accept public delegations at its meetings. However, at least one of the LHIN's current members expressed disagreement with this limitation, and it is not a uniform practice amongst LHINs.[21]

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[21] The HNHB LHIN has suggested that any comment on the part of a Board member that is inconsistent with the board's adopted practice must have been made in their personal capacity, as it would otherwise be a breach of the board members' fiduciary duty. However, the Ombudsman's interviews are conducted under the authority of the

52 While the Hamilton Niagara Haldimand Brant LHIN does send representatives to attend meetings to which the LHIN is specifically invited, we were advised that the board does not encourage board members to attend community consultation sessions arranged by health service providers.[22] The LHIN's senior representatives consistently advised us that the LHIN is responsible for community engagement from a "system" perspective, at the "10,000-foot level," in contrast to community engagement on specific restructuring plans, which they generally viewed as the purview of the health service provider responsible for developing the plan. We were told that the uninvited presence of the LHIN at a public outreach event conducted by a hospital or other health service provider could interfere with the service provider's ability to engage the community effectively.

53 This belief is not shared by all LHINs in Ontario. We learned that a number of LHINs do permit their board members to attend health service provider community sessions, as observers. One senior official for another LHIN remarked that he found this practice very helpful. He explained that in one case where a hospital had been asked by the LHIN to go back and engage in more public sessions, when LHIN officials attended the events, they found a significant discrepancy between what the hospital had advised the LHIN about the community engagements it had undertaken and what LHIN members witnessed first-hand at the additional sessions.

54 The 60-plus complaints that my Office received do not relate to the LHIN's general engagement of the public in relation to broad-based systemic planning and priorities. Rather, it is the LHIN's perceived failure to adequately "engage" the community with respect to two specific initiatives that has led to a flurry of complaints to my Office. This is not surprising. It is one thing to engage in blue-sky thinking and philosophical debate about the future of health care in general. It is quite another when concrete proposals have been put forward which may have a direct and significant impact on the services available to citizens in the foreseeable future.

Ombudsman Act, which all government officials are required to comply with. Our investigations take place in private to encourage candor and to protect the integrity of our process. All interviews conducted during this investigation were conducted with board members in their official capacity, in accordance with the provisions of the *Ombudsman Act*.

[22] However, the LHIN did advise that board members can attend such meetings in their personal capacity as citizens of the community, and that it has recently clarified this to them.

Hamilton Health Sciences "Access to Best Care" Plan

55 Hamilton Health Sciences is a multi-site corporation comprised of six hospitals and a cancer centre.[23] On January 15, 2008, Hamilton Health Sciences publicly announced its "Access to Best Care" plan, or the "ABC" plan. The ABC plan proposed a number of changes to health services delivery in the region, including the conversion of McMaster Children's Hospital at the McMaster University Medical Centre to a Pediatric Centre of Excellence, the transfer of adult inpatient services to St. Joseph's Healthcare and other sites of Hamilton Health Sciences, and the creation of a new Urgent Care Centre.

56 The ABC plan indicates that it "was created with advice and guidance from a wide range of stakeholders," including Hamilton Health Sciences staff, physicians, directors, academic leaders and partners in the health care system.

57 Hamilton Health Sciences held a series of open houses beginning in March 2008 to discuss the proposed integration and its implementation. Many of the complainants to our Office were highly critical of the consultation conducted by Hamilton Health Sciences. They expressed the belief that by the time the plan was unveiled for comment, it was essentially a *fait accompli*. They alleged that Hamilton Health Sciences was really only interested in feedback on how to implement the changes and explain them to the public, not in obtaining stakeholder views for the purpose of plan development.

58 Although the proposed changes could have a direct financial impact on Hamilton Emergency Services (EMS) to the tune of about $1.5 million, Hamilton EMS advised us that it had not been consulted during plan development, and only found out about plan details the same day they were announced to the general public. Critics have suggested that notifying the public after the fact of a fully formed plan is inconsistent with the legislative requirement to "engage the community… when developing plans and setting priorities for the delivery of health services."

59 In accordance with the Act, the LHIN had an opportunity to review the ABC plan and to consider the adequacy of the community engagement around it.

60 The ABC plan was a "voluntary" integration plan. Under the circumstances, Hamilton Health Sciences was required to give notice of the proposal to the LHIN, which in turn had 60 days to consider the plan. The LHIN had the option within that time frame of issuing a proposed decision to prevent the plan from proceeding. If it chose to go this route, this would trigger a 30-day public right to make written submissions concerning the plan, followed by another 30-day period to allow the LHIN to consider the submissions and

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[23] These are: Hamilton General Hospital, Chedoke Hospital, Henderson General Hospital, Juravinski Cancer Centre, McMaster Children's Hospital, McMaster University Medical Centre and St. Peter's Hospital.

reach a final decision. Alternatively, the LHIN could allow the 60 days to pass without issuing a decision, which would result in Hamilton Health Sciences having the go-ahead.

61 In considering whether to issue a decision forestalling a voluntary integration plan, a LHIN must consider the public interest, the extent to which the integration is inconsistent with the Integrated Health Service Plan, and any other matter that it considers relevant. [24]

62 The ABC plan was officially submitted to the LHIN on August 6, 2008, and it was discussed at a public LHIN board meeting on August 26, 2008. The minutes of this meeting indicate that LHIN staff presented a summary of the key features of the plan and explained the LHIN's role with respect to the review and approval of the plan.

63 The LHIN did not specifically invite public comment after receiving the ABC plan for review, but this did not stop citizens from continuing to express concern about the ABC proposals. However, the approximately 40 written submissions from municipal councillors, residents and health care professionals that did make their way directly to the LHIN were rerouted to the corporate hospital board of Hamilton Health Sciences for consideration.

64 On September 12, 2008, Hamilton city council formally wrote to the LHIN, requesting that it conduct community engagement on the full ABC plan before making its decision. In a September 24, 2008 response, the LHIN advised that until its board had an opportunity to discuss and/or debate the plan, any commitment to further consultation would be premature. However, five days later, the LHIN board considered the ABC plan for the last time.

65 At a board meeting on September 29, 2008, the LHIN viewed a multimedia slide presentation on the ABC plan, which highlighted the roles and responsibilities of the LHIN and of hospitals, identified the problems that the ABC sought to address and its proposed solutions, explained how the proposed changes were in keeping with the public interest, and outlined the options of the board regarding the plan. Two of the 51 slides that were presented contained a very brief summary of concerns raised by the community on the plan, including criticism of the extent of public consultation that had been undertaken. After this presentation, the LHIN board passed a unanimous decision, finding that it was in the "public interest not to issue a decision ordering the parties not to proceed with the integration" – effectively allowing the ABC plan to proceed.[25]

66 The following day, a LHIN board member, who had been prevented from considering the plan as a result of a conflict of interest, resigned. In his public letter of resignation, he

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[24] *Local Health Services Integration Act, supra* note 3, s. 27(7).

[25] While the LHIN could have remained silent about the merits of the Plan, it has adopted a practice, where it decides not to prevent a voluntary integration plan, of making a definitive statement in support of the plan.

criticized the board's decision-making process, the lack of public input into the plan and the lack of attendance by LHIN board members at community meetings held by Hamilton Health Sciences to discuss the plan.

67 As the ABC plan was a voluntary integration, and the LHIN did not propose to prevent it from being implemented, there was no formal public right under the *Local Health System Integration Act, 2006* to make submissions on the plan before a final decision was arrived at. However, the distinction between an integration required or restrained by the LHIN, and a voluntary integration that proceeds unabated, was lost on many members of the community, who could not understand why the LHIN had not allowed them an opportunity to be heard on the substance of the plan. Given the general intent behind the *Local Health System Integration Act, 2006*, of allowing health service decision-making at the grassroots level, many citizens – not unreasonably – expected that they would be afforded the chance to voice their views on the specific plan proposals before any decision was made. They were understandably confused and disappointed when the LHIN gave the ABC plan the green light on September 29, 2008 without permitting additional community input.

68 Many of the people who complained to our Office criticized the lack of community engagement undertaken by both Hamilton Health Sciences and the LHIN with respect to the ABC plan. Some suggested that the LHIN did not fully consider their comments, as they were essentially "filtered or sterilized" by LHIN staff in the multimedia presentation. Local media also highlighted concerns with respect to the plan proposals, which many found controversial, as well as the sufficiency of community engagement.

69 During our investigation, LHIN officials explained that it was up to Hamilton Health Sciences to engage the community around the ABC plan, and that LHIN board members were accordingly discouraged from attending Hamilton Health Sciences' open houses where the plan was discussed. While LHIN officials acknowledged that they do have a role in ensuring that a health service provider conducts stakeholder outreach, they stated that they relied on and trusted the information provided by Hamilton Health Sciences concerning its efforts to obtain public input. In response to public pressure, the LHIN did obtain a long list from Hamilton Health Sciences of the consultations it had undertaken, but did not request any additional documentation on the results of the hospital's public outreach. It is not clear whether the hospital would have been in a position to produce documentation recording public feedback had the LHIN actually asked for it. The *Hamilton Spectator* reported that it had inquired into the public response that had been obtained by the hospital during its open houses. The hospital apparently advised the newspaper that the results of the outreach were recorded in the form of personal and mental notes and had been the subject of debriefing conversations held after the open houses had taken place.[26]

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[26] Dana Brown "No rules on input for HHS plan" *The Hamilton Spectator* (16 January 2009) A4.

70 Senior LHIN officials told us that the LHIN did not engage in its own community consultation because it would have been unlikely to elicit any "new information." However, one LHIN board member advised us that he had personally conducted community engagement before casting his vote on the ABC plan. He explained that he had engaged citizens at his golf club, in shopping centres and in line for groceries about their views about creating a dedicated children's hospital. Based on his personal straw poll, he felt that the majority of citizens would be in favour of the proposed integration.

71 In addition to raising concerns about the quality of community engagement surrounding the ABC plan, complainants also questioned how the LHIN board could make decisions on such a major plan after very limited discussions at two public meetings. The LHIN chair and other LHIN representatives explained that it often holds "education sessions" in addition to public meetings at which additional information is obtained and discussed. LHIN officials advised us that the LHIN had discussed the ABC plan on a number of occasions behind closed doors, even before it had been formally presented with the plan. During an "education" session on March 27, 2008, the board discussed the hospital's potential voluntary integration, and on April 8, 2008, senior officials from Hamilton Health Sciences made a presentation to the board concerning its proposals. On July 8, 2008, the board discussed the Hamilton Health Sciences Capital Plan – which included reference to the hospital's Master Planning and Access to Best Care – in a closed session. On September 23, 2008, representatives from St. Joseph's Healthcare made a private presentation to the board concerning urgent care centres like the one proposed in the ABC plan.

72 Another hospital restructuring plan had also been causing waves in the community, sparking calls for greater opportunities for public participation. This plan involved a proposal for a large-scale overhaul of health services in the Niagara region.

Niagara Health System "Hospital Improvement Plan"

73 The Niagara Health System is the largest multi-site hospital amalgamation in Ontario. It comprises seven sites,[27] serving approximately 434,000 residents across the 12 municipalities that make up the Regional Municipality of Niagara.

74 Like other hospitals, Niagara Health System is required, as a term of its service accountability agreement with the LHIN, to maintain a balanced budget. The hospital had failed to achieve a balanced budget under the 2007-2008 service accountability agreement.

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[27] Douglas Memorial Site in Fort Erie, Greater Niagara General Site in Niagara Falls, Niagara-on-the-Lake Site, Ontario Street Site in St. Catharines, Port Colborne Site, the St. Catharines General Site and the Welland Hospital Site.

On May 20, 2008, the LHIN board held a special meeting to consider what to do about the hospital, which by then had been running a deficit for 2007-2008 and had projected a deficit for 2008-2009 of close to $18 million. The LHIN determined that Niagara Health System would have to submit a "Hospital Improvement Plan" or HIP, which would then be used to inform the 2009-2010 service accountability agreement. On May 30, 2008, the LHIN formally notified the hospital of this decision. While the service accountability agreement entitled the LHIN to require the hospital to produce a plan within 30 days, the LHIN allowed the hospital until July 15, 2008 to submi. .s proposal. The LHIN also advised the hospital that it should include information in its submission about the community engagement informing the creation of the plan, but noted, "It is not expected that additional community engagement between receipt of this letter and submission of the HIP to the LHIN be carried out."

75 During our investigation, LHIN officials explained that the Niagara Health System had undergone nine reviews in the previous decade, and the LHIN anticipated that the plan would rely on the information that had already been gathered as a result of those reviews. The LHIN also retained an expert adviser, who had experience in amalgamating and running a multi-site hospital in Ottawa, to comment on the merits and feasibility of the plan developed by the hospital. The LHIN's expert adviser was expected to carry out community engagement on behalf of the LHIN as part of his mandate.

76 Mindful of its obligations under the *Local Health Services Integration Act, 2006 (LHSIA)*, on June 23, 2008, the Niagara Health System's Chief Executive Officer sent an email to the LHIN, enclosing a briefing note concerning, among other things, community engagement, which commented:

> ...*LHSIA* provides no details regarding the extent of the engagement to be undertaken by hospitals nor have the courts yet provided any guidance. It is the opinion of our legal counsel, [...] , that given the materiality and the easily understood nature of some of the changes contemplated as being included in the Improvement Plan, a court would likely expect a robust level of consultation to occur before the hospital board made a firm commitment to implement such a plan. This would likely include one or more public meetings, something that is not possible in the time available. [...]
>
> The NHS, due to time constraints, will *not* be in a position to conduct community engagement on the specifics of the HIP, prior to the board meeting of July 15, which is the same day the HIP is due to the LHIN. Accordingly, the HIP should be submitted subject to future consultation to be engaged in by NHS in order to be in compliance with *LHSIA*.

77 Despite its reservations concerning the ability to engage the public on such short notice, the hospital did undertake some attempts to gauge community views. For instance, on June 26, 2008, the hospital wrote to the LHIN, indicating that a new section of its external website would be going live that day. It explained that this section featured information

and "educational material with a series of questions to seek feedback from the community regarding how services can be delivered differently to inform the HIP submission."

78 On July 15, 2008, Niagara Health System submitted its Hospital Improvement Plan to the LHIN.

79 The LHIN's expert adviser and his team then held community consultation meetings in Fort Erie, Niagara Falls, St. Catharines, and Port Colborne to discuss the plan with stakeholders. LHIN staff and board members also attended these meetings to observe. Meetings were also held with Niagara Emergency Services, transit leaders, business and philanthropic leaders, and the mayors and councillors of affected communities. The LHIN received 155 submissions and complaints concerning the hospital improvement plan, including a 14,000-signature petition from Fort Erie residents. Fort Erie was particularly vocal regarding its concerns about the plan. At the community consultation meeting held there, more than 5,000 residents showed up to oppose the plan.

80 The HIP generated considerable public interest, including strong criticism from many stakeholders about the consultation process. In an attempt to dispel some of the confusion about community engagement, the LHIN chair wrote a letter to the editor that appeared in the *St. Catharines Standard* on September 2, 2008. In that letter, she explained:

> The LHIN will receive [its expert adviser's] recommendations on the plan … on October 28… At the same time, the NHS continues to receive feedback on its plan from the communities it serves and the stakeholders it works with. The NHS is developing a report that identifies issues and options proposed by individuals and communities. These findings will be an addition to the plan and will be provided to the review team. The deadline for inclusion in this report is Monday, Oct. 6. … Ideas as to how communities can advance the implementation of the plan and the role they are willing to undertake will be welcome advice to the NHS and the review team.[28]

81 At a board meeting on October 28, 2008, the LHIN received its expert adviser's report and recommendations on the plan. The board forwarded the report on to the hospital, with the direction that it be considered along with the hospital's consultation in the preparation of a final Hospital Improvement Plan.

82 The Niagara Health System prepared an amended plan, which was provided to its Community Standing Committees for approval. The Fort Erie Community Standing Committee refused to approve the HIP, which included a proposal to convert the Douglas Memorial site to a 24/7 urgent care centre. While the hospital's board of directors did not

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[28] "Input important in Hospital Improvement Plan," Letter to the Editor, *The St. Catharines Standard* (2 September 2008) A6.

consider the Standing Committee's position to be unreasonable, it determined that it would continue to advocate for the implementation of the HIP at all of its sites, including Douglas Memorial. Accordingly, the hospital submitted its amended plan to the LHIN on November 19, 2008.

83 At a LHIN board meeting on November 25, 2008, the LHIN asked the hospital to remove those elements of the HIP relating to Fort Erie, so that the LHIN could better assess the implications with respect to the Douglas site. In accordance with this direction, the hospital provided the LHIN with an updated plan on December 10, 2008.

84 On December 16, 2008, the LHIN board considered the HIP yet again. At that meeting, the LHIN decided to direct that the Douglas site be converted into an urgent care centre, and that the changes necessary to accomplish this be reflected in the plan.

85 In accordance with the Act, the public was given a 30-day period during which additional submissions could be made regarding the LHIN's proposed integration decision. At the end of this period, the LHIN confirmed its decision.

86 The Hospital Improvement Plan attracted considerable local controversy. In its consultation summary report, the hospital acknowledged that there had been criticism from some stakeholders concerning the sufficiency of public consultation about the plan, which it attributed to the short time frame for development set by the LHIN. In his report, a member of the expert adviser's team noted that the short time frame to produce the plan left little time for broad consultation and suggested that there was a "price to pay" for limited consultation.

87 Once again, we received complaints concerning the fact that the LHIN board only considered the HIP in a few open meetings and decisions were made after limited public discussion, leaving citizens uncertain as to the basis for the board's decision-making. It was alleged by some complainants that at one open meeting, board members asked many questions that were not answered. They wondered how a decision could be made with significant information still outstanding. However, we were told by a LHIN official that answers were eventually obtained in a closed "education" session and that they were later discussed in an open board session. The LHIN has also indicated that answers were provided on its website.

88 As in the case of the ABC plan, the LHIN board advised us that it had held private "education" sessions to consider additional information pertinent to its decision-making. Even before it directed that the Niagara Health System prepare a Hospital Improvement Plan, on April 8, 2008, the board met with representatives of the hospital to discuss the previous reviews that had been conducted. Once the planning had begun in earnest, the Chief Executive Officer of Niagara Health System met privately with the board on June 10, 2008, and again on July 7, 2008, to make presentations, which included discussion of HIP proposals. On August 8, 2008, the board met *in camera* to discuss a number of issues relating to the Niagara Health System, including the Hospital Improvement Plan, and on

August 25, 2008, the board met privately with its expert adviser and his review team. On November 18, 2008, the LHIN board held a closed meeting in which it considered the plan, and also listened to presentations by Niagara Emergency Services and the mayors of Port Colborne and Fort Erie, in which they highlighted their issues and concerns with the plan. Finally, on December 9, 2008, the board conducted a private video conference with its expert adviser.

89 To add to the public perplexity surrounding community engagement by the LHIN, in the case of the Niagara Health System Hospital Improvement Plan, it did take part in community outreach in a much more direct way than in the case of the ABC plan. LHIN officials explained that while the LHIN does not generally interfere in the community outreach undertaken by health service providers, the Hospital Improvement Plan had been taken at its initiative and proposed extensive changes to the health services to be provided to residents, while the ABC plan was a voluntary initiative and only involved relocation of services. Unfortunately, these differences were not necessarily obvious to the LHIN's stakeholders and community members.

90 During our investigation, the LHIN chair acknowledged that one of the lessons that she had taken away from her experience with the Hamilton Health Sciences ABC plan was that all the work that the board undertook to prepare for its deliberations – including the conversations held with local politicians where support for the plan was privately expressed – should have been made available to the public. She indicated that this learning was applied in the deliberations related to the Niagara Health System HIP decision-making process. LHIN staff also advised us that the LHIN's practice has changed and that now when staff summarizes community feedback, a paragraph from each submission is included to give board members a better flavour of citizen concerns.

91 While the LHIN has more recently made efforts to improve the openness of its process, it is clear that significant improvement is required to ensure that community engagement is not just a superficial afterthought, but a genuine and material exercise that assists and informs LHIN decision-making.

Rules of Engagement

92 As illustrated by the experience of the Hamilton Niagara Haldimand Brant LHIN, there is considerable uncertainty about what constitutes community engagement under the *Local Health System Integration Act, 2006*. While there is some value in allowing for a flexible process that can be adapted to satisfy local differences, there is also a need for greater definition of what is a founding principle of the LHIN system.

93 At a minimum, stakeholders need to know what and what not to expect from health service providers and LHINs when it comes to community engagement. There should be some

basic and consistent ground rules. It should be clear at what stage of the planning process community engagement should take place, and that it is taking place. Community engagement should not happen by surprise or ambush. Stakeholders should know that their views and comments are being sought as part of a community engagement process. They should be given sufficient information about the issue under consideration to allow them to take part in informed discussion. Adequate records of community outreach should also be kept and made available to ensure that stakeholder views are accurately represented. Little weight can be placed on stakeholder views that are obtained in circumstances where stakeholders don't fully realize the reason why their views are being solicited and the purpose to which they will be put.

94 Community engagement should also strive to reach a large cross-section of the stakeholder community. It should not be arbitrary or elitist. Everyone should have an equal opportunity to voice his or her views on the future of local health services. Participation should not be dependent on whether a resident can afford to golf at the same club as a LHIN board member or happens to shop at the same stores. While casual conversations with community members will undoubtedly always take place and should not necessarily be discouraged, they should not be seen as satisfying a LHIN's legal obligation to engage the community with respect to regional health services decisions.

95 The Ministry has an overarching responsibility for the administration of the Act. In order to fulfill this responsibility, it should take the lead to ensure that community engagement surrounding local health services is robust and real, by helping to establish some basic general standards.

96 In the case of the Hamilton Niagara Haldimand Brant LHIN, the LHIN should also use its website, meetings and other methods to educate the community about its general practices relating to community engagement, as well as the nature of engagement to be expected with respect to general systems planning and specific plans under consideration – including clarifying the relative roles of health service providers and the LHIN. Stakeholders will continue to be frustrated unless they are encouraged to develop more realistic expectations of their role in decision-making about local health services.

97 In order to engender greater public confidence and comply with the principles of openness and transparency underscoring the Act, the LHIN must also immediately abandon its practice of holding closed meetings for educational purposes. The LHIN board's practice of holding private "education" sessions is a clear contravention of the Act. There is no exception allowing for the board to meet behind closed doors for this purpose. The LHIN's By-law 2, to the extent it attempts to redefine "meeting" to exclude educational sessions, is of no force and effect. Its by-law cannot override the statutory requirement mandating open meetings.

98 Had the Legislature intended for LHINs to have the ability to meet in secret for the purposes of education, the Act would have said so. Since 2007, under amendments to the *Municipal Act, 2001,* municipalities have had the express statutory authority to hold

education and training sessions in certain circumstances, provided procedural requirements have been met and at the meeting no member discusses or otherwise deals with any matter in a way that materially advances the business or decision-making of the municipal body holding the meeting. Quite properly, there is no similar exception applicable to the LHINs. In the context of decision-making about local health services, private educational sessions are completely inconsistent with the intent of the Act, including its emphasis on community engagement. By its admission, the board often conducts these sessions to obtain information and clarify matters in connection with specific plans under its consideration. In such circumstances, these sessions are not purely educational exercises, but activities directed at moving the deliberative process forward. Similar closed meetings would not be sanctioned under the *Municipal Act*, as they are clearly being held for the purpose of materially advancing business and decision-making. In the LHIN context, this is the very type of conduct that the Act contemplates will take place in full view and with the full knowledge of the public.

99 While the LHIN may have been well-intentioned in holding its "education" sessions, these meetings were plainly illegal. It is not surprising that stakeholders were left confused and frustrated by the engagement process when they were left out in the dark about matters directly informing the LHIN's decision-making.

100 LHINs must make difficult and sometimes unpopular choices about health services. They will never please everyone. However, I believe that the public response to the Hamilton Niagara Haldimand Brant LHIN's recent consideration of two plans illustrates the danger of following practices that undermine openness and transparency, and in doing so, attract public suspicion and conjecture.

Opinion

101 The Hamilton Niagara Haldimand Brant Local Health Integration Network's failure to follow and ensure that health service providers followed a clear and transparent process of community engagement in relation to its consideration of the Hamilton Health Sciences Access to Best Care Plan and the Niagara Health System Hospital Improvement Plan was based, in part, on lack of clarity in the *Local Health System Integration Act, 2006*, which is unreasonable, in accordance with s.21(1)(b) of the *Ombudsman Act*.

102 The Hamilton Niagara Haldimand Brant Local Health Integration Network's failure to ensure that the community was adequately educated around the community engagement process was also unreasonable and wrong, in accordance with ss.21(1)(b) and (d) of the *Ombudsman Act*.

103 Finally, the Hamilton Niagara Haldimand Brant Local Health Integration Network's practice of holding closed education sessions is contrary to law, in accordance with s. 21(1)(a) of the *Ombudsman Act*.

Recommendations

Accordingly, I am making the following recommendations:

Recommendation 1
The Ministry of Health and Long-Term Care should take all steps necessary to prepare and put forward guidelines setting out basic standards to be met by health service providers and Local Health Integration Networks when conducting community engagement under the *Local Health System Integration Act, 2006*.

Subsection 21(3)(b) *Ombudsman Act*

Recommendation 2
The Hamilton Niagara Haldimand Brant Local Health Integration Network should take all steps necessary to educate the community about its general practices relating to community engagement, as well as the nature of community engagement to be expected with respect to systems planning and specific integration plans, including clarifying the relative roles of health service providers and the Local Health Integration Network.

Subsection 21(3)(b) *Ombudsman Act*

Recommendation 3
The Hamilton Niagara Haldimand Brant Local Health Integration Network board of directors should immediately amend its By-law 2 to comply with the open meeting requirements of the *Local Health System Integration Act,* 2006 and cease its practice of holding closed educational meetings.

Subsection 21(3)(b),(g) *Ombudsman Act*

Recommendation 4
The Ministry of Health and Long-Term Care and the Hamilton Niagara Haldimand Brant Local Health Integration Network should report back to my Office at quarterly intervals on their progress in implementing my recommendations until such time as I am satisfied that adequate steps have been taken to address them.

Subsection 21(3)(b),(g) *Ombudsman Act*

Responses

104 At the conclusion of my investigation, a preliminary report and recommendations were provided to both the Hamilton Niagara Haldimand Brant Local Health Integration Network and the Ministry of Health and Long-Term Care for their review and comment.

Ministry Response

105 On August 24, 2009, the Ministry of Health and Long-Term Care responded to my preliminary report and recommendations. The Ministry acknowledged that the government would always have the ultimate responsibility for providing Ontarians with high-quality, accessible health care services, and indicated that as Crown agencies, LHINs work in partnership with the Ministry to ensure that unique local health care needs and priorities are addressed.

106 The Ministry supported my recommendation for greater clarity and transparency on community engagement and undertook to work with the LHINs to strengthen community engagement obligations under the jointly negotiated Ministry-LHIN Accountability Agreement (**Recommendation 1**). The Ministry noted that it had already worked with the LHINs to develop *Engaging with Impact: Targets and Indicators for Successful Community Engagement by Ontario's Local Integration Networks,* a document that proposes a series of recommendations and indicators that can be used to assess performance and strengthen community engagement between the LHINs, providers and the public. The Ministry also advised that it was working with three LHINs (North West, South East and Central) to develop a strategy for disseminating this information to all LHINs.

107 The Ministry also supported my recommendation for the Hamilton Niagara Haldimand Brant LHIN to ensure that it educate its community about engagement with respect to system planning and integration (**Recommendation 2**). It committed to communicate this expectation to the HNHB LHIN and all LHINs to ensure better understanding across the province regarding community engagement.

108 In addition, the Ministry undertook to work with all LHINs to clarify expectations concerning public board meetings (**Recommendation 3**). Finally, the Ministry agreed to report back to my Office twice a year over the next two years regarding its progress (**Recommendation 4**).

109 On June 22, 2010, our Office obtained an update from the Ministry on the steps that it had taken in response to my recommendations since receiving my preliminary report. We were advised that LHIN and Ministry representatives had been involved in a working group directed at developing core principles relating to community education and best practices. We were told that while the guidelines were not yet finalized, in future the LHINs will be expected to develop a yearly community education plan, evaluate participant awareness

through surveys at the end of community education activities, and report to the LHIN boards the community input that has been received. The guidelines will be reviewed annually by a Community Engagement Network, which will update them based on feedback and new information. In addition, each LHIN will establish an evaluation committee composed of external and internal LHIN resources to review community engagement practices to ensure the LHINs are meeting best practices expectations.

110 The Ministry also advised that it has retained a consultant to meet with the LHINs to address good governance and has been working with the LHINs on the development of a good governance guide. In addition, it met with the HNHB LHIN and emphasized that the LHIN should not be making decisions during *in camera* meetings, unless specifically provided for in the exceptions to the open meeting requirements, and that it should be more explicit about what it has done in open board meetings.

111 On June 22, 2010, the Ministry advised that it was of the view that the LHIN's By-law 2 allowing closed meetings for the purpose of "education" was consistent with the intent of the *Local Health Services Integration Act*. We were told that from the Ministry's perspective, the Act only requires that a LHIN board meet openly if it is actually making a decision.

112 I find this flip-flop by the Ministry to be particularly troubling. The requirement for LHINs to hold open meetings is a very significant part of the LHIN process. In respect of open meetings at the municipal level, it has been said:

> The democratic legitimacy of municipal decisions does not spring solely from periodic elections, but also from a decision-making process that is transparent, accessible to the public, and mandated by law.
>
> – Hon. Madam Justice Louise Charron, Supreme Court of Canada

113 It is a very serious matter to close a LHIN board meeting to the public. The Act expressly sets out only 11 exceptions to the open meeting requirement and prescribes procedural steps that must be followed before a meeting can be closed. Before closing a meeting, a public vote must first be taken, and the nature of the matter to be considered at the closed meeting as well as the general reasons why the public is to be excluded must be clearly stated.

114 If the Legislature had intended for there to be another exception to the open meeting requirement for "education" sessions it surely would have said so, as it did in the recent amendment to the *Municipal Act*. The open meeting requirements are remedial and intended to be interpreted broadly, consistent with the public interest in transparency and accountability. The only provisions that are to be narrowly interpreted in this context are those providing for exceptions to the general rule that meetings should be held openly. Accordingly, the open meeting requirements in the *Local Health System Integration Act* should be construed expansively in the public interest rather than improperly constricted for the sake of the LHIN's convenience. There is simply no exception in the Act that

would permit this type of closed session to occur, nor should there be.

115 I fully agree with the proposition that not all gatherings of the LHIN board of directors will be meetings that should attract the requirement that they be held open to the public; for example, a purely social gathering where no discussion takes place relating to the LHIN's operations would not trigger this obligation. The working definition of "meeting" that I have adopted in the context of municipal open meetings recognizes that, at times, members of an organization will meet in informal circumstances in which there is no need for the public to be present to ensure the "democratic legitimacy" of the organization's operations. I consider that a "meeting" has taken place if members of the body come together for the purpose of exercising their power or authority or for the purpose of doing the groundwork necessary to exercise that power or authority. Gatherings of the LHIN board of directors (or meetings with other entities) held to educate members about matters relating to the exercise of their authority would certainly come within this definition. There is no compelling policy reason to hold these meetings privately; quite the opposite. Any meeting at which matters are discussed that might have a bearing on a future decision or exercise of LHIN authority should be held openly, unless the subject matter to be considered comes squarely within the statutory exceptions.

116 My investigation revealed that while considering the ABC plan, the LHIN board of directors met on at least four occasions in private "education" sessions without notice to the public to discuss matters related to the integration – sometimes hearing representations from health service providers. In the case of the Niagara Health System Health Improvement Plan, the board met behind closed doors at least seven times – sometimes with health service providers and specific stakeholders. These meetings were patently held for the purpose of doing the groundwork necessary to exercise the authority of the LHIN. This is the very type of meeting that the legislation intended to keep open to the public.

117 Even the education exception applying to municipal meetings does not allow closed sessions to take place that materially advance business or decision-making. It is not just the actual decision-making that must be open, but also the sessions in which information is obtained and considered leading up to that decision. Unless this process is open, the decision may be transparent, but the reasoning behind it will remain opaque and the public will be left confused, frustrated and dissatisfied.

118 I believe the Ministry's position regarding the LHIN practice of holding closed educational meetings is antithetical to the community engagement principles in the Act, wrong in law, and perpetuates a disservice to the people of Ontario, who are entitled to know how decisions affecting community health care are arrived at. The Deputy Minister, in his July 15, 2010 letter, noted that the Ministry is continuing to review the concerns raised by my Office about "educational meetings" and has undertaken that the Ministry "will be taking action to clarify educational meetings and enhance the already extensive regulatory framework designed to foster openness and transparency." I strongly encourage the Ministry to reconsider its position with respect to the open meeting requirements in the Act.

LHIN Response

119 Unfortunately, the response received from the Hamilton Niagara Haldimand Brant LHIN was also not particularly encouraging.

120 The Hamilton Niagara Haldimand Brant LHIN's response to my preliminary report and recommendations was received August 25, 2009. The LHIN provided an 11-page, detailed critique of my report, including factual clarifications and even stylistic suggestions, some of which have been incorporated into this final report. The LHIN did not acknowledge any failings with respect to the community engagement process, and it rejected the conclusions that I had drawn and the recommendations that I had made concerning its community engagement efforts and the conduct of board meetings.

121 The LHIN took issue with many of my findings. For instance, the LHIN disputed my reference to there being no minimum standards for community engagement, suggesting that this conclusion contradicted references in the report to specific provisions of the *Local Health System Integration Act, 2006*. It stated that the statutory obligations were "not open to interpretation" and assumed "that the Ombudsman intended to observe that in some circumstances, LHINs may do community engagement beyond their minimum obligations," which it considered, "entirely reasonable as the evidence provided to the Ombudsman indicates that the scope and content of community engagement will vary depending on the purposes for the engagement and the community."

122 As the LHIN pointed out in its response, the Act does set out an obligation on the part of LHINs to engage the community with respect to the local health system, including when establishing priorities, and indicates that certain groups must be consulted in this process. It also suggests some methods that can be used for community engagement. In addition, in certain cases, a right to make formal written submissions arises. Health service providers are also required to engage the community when developing plans and setting priorities. However, the provisions concerning community engagement are very general in nature. I remain of the view that there are no clear and consistent standards as to what constitutes

community engagement or guidelines as to how it should be accomplished. This position is consistent with the information we received from a Ministry official during the investigation, who advised that the community engagement provisions in the Act had been deliberately drafted in broad terms to enable them to be adapted to local needs. In responding to my report, the Ministry did not dispute my observation that there is a lack of definition surrounding community engagement, and – more importantly – it has undertaken to take steps to achieve greater clarity and transparency with respect to the community engagement efforts of both health service providers and LHINs.

123 From its response, it appears that the LHIN did not fully grasp the implications of my opinions and recommendations. With respect to my concerns about the LHIN's failure to follow a clear and transparent process of community engagement, and my recommendation (**Recommendation 1**) that the Ministry provide better guidance in this area, it commented:

> While the LHIN understands that it may be the Ombudsman's opinion that the statutory obligations are insufficient, this is very different from it being the Ombudsman's opinion that the LHIN failed to fulfill its obligations. There is no evidence in the report, nor would we expect in the record, that supports an opinion or finding that the LHIN acted improperly or contrary to law in respect of community engagement. If this LHIN is reading this aspect of the Report correctly, the LHIN asks that the Report make it very clear that it is the Ombudsman's opinion that the legislation is lacking, not the actions of the LHIN.

124 For the benefit of the LHIN, I would like to make it clear that while I believe that greater precision in the legislation would certainly have assisted, and that the lack of standards for community engagement was definitely a problem, I believe that the LHIN had an independent responsibility to ensure that community engagement was conducted in a manner that was open and transparent. Consistent with the accountability relationship existing between the LHIN and health service providers, it was incumbent on the LHIN to take adequate steps to ensure that the community engagement conducted by health service providers relating to local health services planning and priorities was compliant with the spirit of the Act and service accountability agreements. In my view, there is sufficient evidence documented in this report to suggest that the LHIN's conduct with respect to community engagement was deficient.

125 As I have noted elsewhere in this report, I did not investigate the community engagement efforts of the health service providers involved in the integration plans considered in this investigation, and have consequently made no findings relating to the adequacy of the community engagement that they conducted. However, it is evident that in the case of the HNHB LHIN, it was largely content to rely on the word of health service providers as to the degree of community engagement they had conducted. No formal records relating to community engagement were required to be kept, and there was no scrutiny by the LHIN of the results of outreach efforts on the part of health service providers. It was only in response to public concerns that the LHIN actually requested a list of consultations that had been carried out in relation to the Hamilton Health Sciences Access to Best Care Plan. In the case of the Niagara Health System Hospital Improvement Plan, the health service provider itself expressed concern about the adequacy of community engagement – and the LHIN's expert advisory team recognized that there had been limited consultation, given the short time frame set by the LHIN.

126 In recognition that there is a systemic element to this issue, and other LHINs throughout Ontario would undoubtedly benefit from a broader remedy, the most direct route to solve this problem was to enlist the Ministry's assistance in ensuring greater clarity, consistency and transparency around the community engagement obligation. I am pleased that the Ministry appears to understand this aspect of my report and has undertaken to work with all Ontario LHINs to address it.

127 In its response, the LHIN also questioned my opinion and recommendation related to the need to educate the public about the nature of community engagement (**Recommendation 2**). It remarked:

> The LHIN understands that this recommendation arises because some or all of the 60 complainants appear to have indicated to the Ombudsman that if they had understood the scope of the community engagement better, they would not have made the complaint. In short, the complaint was not about the nature of the decision, or even access to the process, but rather a lack of understanding of the legislation. If this is a fair conclusion to draw from the Report, the LHIN would ask that the Ombudsman review the Report and remove any tone, word usage, or statement that implies or would allow a reader to reach an alternate conclusion.

128 The LHIN reviewed the community engagement activities that it had undertaken with respect to both the Hamilton Health Sciences Access to Best Care Plan and the Niagara Health System Hospital Improvement Plan, and noted:

> Given its current comprehensive approach to community engagement, it would help the LHIN to evaluate and improve its processes as well as target the educational effort the Ombudsman is seeking, if the LHIN better understood the gap that the Ombudsman's recommendation is trying to address.

> The public evidence and that collected by your office, reflects the LHIN's appreciation of community engagement as a "genuine and material exercise, which assists and informs LHIN decision-making." It does not reflect a belief that community engagement is … "just a superficial afterthought." To state otherwise… is simply wrong and an extraordinary disservice to the staff, board members and community of the LHIN. The LHINs are … still learning how to fulfill [their] obligations in an effective and efficient manner and this LHIN practices continuous improvement. If you are not merely recommending that the LHIN educates the public on the legislation, it would be of great value to us to understand how the community engagement processes and opportunities in respect of the more recent NHS integration were unreasonable or otherwise deficient.

129 My investigation revealed that the LHIN failed to adequately educate the public about the nature of community engagement that was to be expected with respect to specific integration plans under consideration. The HNHB LHIN did not clearly distinguish the difference between community engagement at the health service provider level and at the LHIN level. In the case of the Niagara Health System Hospital Improvement Plan, the LHIN had to write a letter to the editor of a local paper to try to dispel some of the misunderstandings and concerns that were circulating. Many who complained to our Office were left frustrated, confused and dissatisfied by the public consultation process. I believe it is incumbent on the LHIN to recognize that it is responsible for ensuring that the community is given sufficient information to understand the rules of engagement from the outset.

130 With respect to my concerns about the closed "education" sessions held by the LHIN and my recommendation that the LHIN amend its by law and cease its practice of holding closed educational sessions (recommendation 3), the LHIN sought to justify its conduct by virtue of the fact that it has the right to manage and control the board of directors and to pass by-laws and resolutions for conducting and managing the affairs of the LHIN. It observed:

> Recognizing that it would not be reasonable to interpret the bare words of the Act to require public notice of an incidental encounter of two or three board members at a local coffee shop, or the presence of several board members on a golf course as a board meeting, the Board took it on itself – as it is permitted to do – to provide a definition for a board meeting that meets the spirit and intent of the Act. It adopted a definition that incorporates the concept of which a board is properly constituted for the conduct of business and what the conduct of business entails. Specifically:
>
> > "Board Meeting" means a meeting of the Board for the purpose of making a decision or recommendation, the taking of an action or the giving of advice in respect of any matter within the Board's jurisdiction. A meeting

> of board members for social, educational or purposes other than conducting [LHIN] business is not a Board meeting. Where the Board Members attend a meeting held by another organization or entity, or visit another organization or entity, the meeting will not be considered a Board Meeting subject to this by law, unless the Board members will be making a decision or recommendation, taking an action or giving advice to the [LHIN] in respect of any matter within the Board's jurisdiction.

131 As a matter of basic statutory construction, while the LHIN may issue by-laws dealing with its board meetings, it cannot, in doing so, limit the application of its statutory obligation to hold open meetings. The LHIN submits that not all gatherings are meetings and its by-law permits it to meet in private as long as the LHIN board does not conduct business. As I have already discussed with respect to the Ministry's response, while not all gatherings will attract the open meeting requirements, I believe that the closed "education" sessions the LHIN purported to hold in relation to the Hamilton Health Sciences ABC plan and Niagara Health System HIP were required by law to be held openly. In addition, contrary to the LHIN's position, these meetings were clearly held to address board business. They were not held to simply train or educate board members generally and they were certainly not social get-togethers. Despite this, the LHIN disputes my opinion that the practice of holding closed educational sessions in connection with integration plans is illegal and argues that its practice is "fully consistent with the full spirit and intent of the legislation."

132 The LHIN expressed the view that our opposing views about the legality of holding these private sessions represent "a reasonable difference of opinion." I disagree. This is not a grey area. The law is not unclear or ambiguous. Despite its arguments to the contrary, in which the Ministry appears to be complicit, I remain confident the LHIN has repeatedly violated the statutory open meeting provisions of the *Local Health System Integration Act, 2006*. Unfortunately, the LHIN's apparent failure to grasp the significance of its transgressions, and its reluctance to alter its practice, do not bode well for the integrity of the LHIN's decision-making in future. Failure to ensure openness and transparency with respect to the LHIN's operations ultimately has the potential to completely undermine the confidence of the local community.

133 The HNHB LHIN was critical of much of the content of my report, including the language used and the analysis employed. It commented quite extensively on what were, in its view, "inappropriate omissions, inadvertent innuendo and highly subjective, rather than objective conclusions." I found the LHIN's response overtly defensive rather than introspective in tone. For instance, while not "diminishing the importance" of the complaints I had received, the LHIN emphasized that they did not represent "many" complaints, when the number of citizens serviced by the LHIN was considered. It then proceeded to call on my Office to provide a detailed breakdown of the complaints, including percentages, in relation to the various issues of concern considered in my investigation. The LHIN also questioned several references in the report that simply reflected the evidence obtained from

stakeholders and official government sources.

134 Finally, the LHIN ended its response by remarking:

> The LHIN understands that the Ombudsman has concluded that there are a number of areas in which improvement could be made. The LHIN also understands that despite its best efforts, it will never be able to please everyone in its community all the time. There will always be disagreements over what is in the best interests of the LHIN as a whole and it will always be left to the LHIN to make that decision. Constant improvement is a goal of this LHIN and the LHIN welcomes constructive criticism and suggestion for improvement that will enable it to improve the accessibility and acceptance of its decisions. To this end, the LHIN does appreciate the spirit in which the Ombudsman's recommendations are made. Moreover, the LHIN respects the effort that was made by the Ombudsman and in particular, the Ombudsman's staff, to understand the LHSIA, the LHIN and the difficult decisions that the LHINs are called upon to make with respect to local health services.

135 Unfortunately, while the LHIN purports to welcome constructive criticism, I found its response generally dismissive of my report and recommendations. The LHIN has not accepted that any of my negative findings regarding its conduct are warranted or undertaken to take any concrete steps to improve. While the Ministry acknowledges that change is necessary to ensure the intent of the LHIN system is fully actualized, the Hamilton Niagara Haldimand Brant LHIN appears to remain resolute in its conviction that its conduct was beyond reproach, and seeks to place the onus on my Office to further justify my concerns. The LHIN's lack of insight is regrettable. Frankly, after receiving this response, I was disappointed and worried that unless the LHIN adjusts its attitude and its actions, trust in the LHIN will erode and the integrity of the LHIN system in its community will be undermined.

136 On June 23, 2010, my Office spoke with Hamilton Niagara Haldimand Brant LHIN officials, including the Chair, to obtain information on any initiatives it has undertaken since responding to my preliminary report. At that time the LHIN advised that it had enhanced its speakers bureau and had been talking with the public and community groups about community engagement. It has also started including on its meeting agenda a community engagement chart showing all of the community engagement it has conducted. The LHIN has also added a standing item on the public meeting agenda entitled, "Report of the board members on Community Engagement" and time is set aside at each public meeting for any board member who may have participated in community engagement to share information with the rest of the Board and the public. This could include discussions that the member has had with people in shops, on the street or at more formal events.

137 The LHIN also advised that it has started to explore using social media to reach a greater demographic and to educate the public about what it is doing in relation to community engagement. In addition, it has launched a bi-weekly electronic publication called

"LHINsight" in which it proactively publicizes communication engagement activities. Anyone who is interested may request to be on the electronic mailing list for this publication.

138 The LHIN has also been involved in the provincial working group developing tools and performance metrics for community engagement, which will include "ethical planning guidelines" that would formally commit the LHIN to declare what community engagement it is conducting and with whom. The LHIN expressed the view that the guidelines for community engagement that are under development by the Ministry would not represent a change for it, since they would merely formalize the LHIN's current practices.

139 The LHIN has been involved as part of a national study group as well, working on addressing what community engagement is, what works and what does not.

140 The LHIN indicated that it continues to engage with local media and politicians to discuss community engagement. It has also held meetings with health service providers to talk about the role of the LHIN and its expectations of health service providers with regard to community engagement. The LHIN has recently encouraged greater sharing of information with health service providers. Niagara Health System invited the LHIN to participate in a series of community engagement meetings regarding the implementation of the Hospital Improvement Plan and LHIN board members attended early community sessions and other sessions as observers. The LHIN has also established an advisory working group with Niagara Health System for monitoring implementation of the Hospital Improvement Plan, including with regard to community engagement. A similar working group has been established with Hamilton Health Sciences, and updates on community engagement along with written updates on the implementation of the ABC plan are provided to the LHIN board.

141 Finally, the LHIN has also added a section to its website called "Engaging you, our community," which provides general information on community engagement.

142 With respect to governance issues generally, the LHIN noted that it participated in a review process, which included consideration of its practices, and that it was recognized as a top performing board.

143 While the HNHB LHIN has taken some steps in the last year to provide more structure and information surrounding its community engagement processes and to monitor the community engagement undertaken by health service providers, there is still work to be done in this regard. For instance, its website does not clearly distinguish the obligations with respect to community engagement to be carried out by health service providers and the LHIN itself, nor does it distinguish between instances where a voluntary plan is being considered and those where the board has required a plan to be submitted.

144 In addition, I remain concerned that community engagement still appears to be an amorphous concept that continues to include casual conversations in shopping lines or on

the golf course. Community engagement must be informed and not dependent on where you shop or play. It is difficult to see how a casual conversation with the man or woman on the street can be seen as satisfying any aspect of the LHIN's community engagement obligation.

145 It is possible that the current initiatives undertaken by the Ministry may provide greater definition and certainty with respect to the community engagement obligations. However, this clearly remains a work in progress. I will continue to closely monitor and assess the progress made by the HNHB LHIN specifically, and by the Ministry generally with respect to the broader LHIN community.

André Marin
Ombudsman of Ontario

Appendix

Final response letters from
Ministry of Health and Long-Term Care

and

Hamilton Niagara Haldimand Brant LHIN

Ministry of Health and Long-Term Care

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HLTC2980DC-2010-1226

Mr. André Marin
Ombudsman of Ontario
Office of the Ombudsman of Ontario
483 Bay Street, 10th Floor
Toronto ON M5G 2C9

Dear Mr. Marin:

I am writing to acknowledge receipt of your letter, dated June 29, 2010, and your report into the investigation of the community engagement decision-making process of the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN).

The ministry has carefully reviewed the report and appreciates the concerns identified and the recommended steps to address those concerns. Your report correctly points out the importance of community engagement to the LHIN model and how the public benefits from such engagement. For example, the HNHB LHIN, when developing their clinical services plan, engaged more than 800 Ontarians, including health service providers, stakeholders and residents. Furthermore, over 1,000 community members participated in 12 open houses hosted by the LHIN across their region. The clinical services plan provides a long-range picture of what the health system in the LHIN will look like to meet the current and future needs of residents.

Both the ministry and LHINs are committed to openness and transparency as guiding principles for the LHIN model and continue to work to strengthen and improve community engagement processes.

As was communicated to you in an August 24, 2009 letter, the ministry and LHINs have taken concrete steps to ensure greater clarity, consistency and transparency with respect to community engagement. The ministry and LHINs worked together to develop robust community engagement guidelines that include principles, best practices and indicators for measuring the effectiveness of community engagement. These measures will not only strengthen community engagement processes across the province by establishing a set of minimum specifications for community engagement, but should also improve public accountability and transparency of community engagement practices and products.

The guidelines were distributed to the LHIN CEOs July 15, 2010 for information prior to their implementation. It is expected that the LHINs will begin to implement them shortly thereafter.

.../2

Mr. André Marin

The ministry is continuing to review the situation with respect to your concerns related to educational meetings. As I mentioned earlier in my letter, we believe that it is important for LHINs to conduct themselves openly and transparently and that the LHINs do work hard to meet this high standard. We believe that it is important to find the appropriate balance between transparency and accountability and the LHIN boards' need to build their knowledge and capacity to effectively manage their local health care system.

We will be taking action to clarify educational meetings and enhance the already extensive regulatory framework designed to foster openness and transparency.

Furthermore, the ministry will report on progress on a quarterly basis while we continue to work through these issues.

Thank you for the opportunity to respond to your report.

Sincerely,

Saäd Rafi
Deputy Minister

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July 6, 2010

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OMBUDSMAN ONTARIO
CORPORATE SERVICES

Mr. André Marin
Ombudsman of Ontario
Bell Trinity Square
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Toronto ON M5G 2C9

Dear Mr. Marin:

Thank you for your letter of June 29, 2010, providing me with a copy of your final report of the investigation of the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN).

I would like to assure you that the HNHB LHIN has carefully considered all of your findings, and while I appreciate having another opportunity to respond to your report, my letter and submission dated August 25, 2009, which is attached to this letter, accurately portrays the LHIN's response to your comments and recommendations.

We have further considered your response regarding meetings; however, we do not believe that the Board Education sessions are illegal. All deliberations and decisions have and continue to be made in the open Board Meetings and/or appropriately constituted closed sessions.

We remain committed to community engagement and to the spirit and intent of the legislation and its tenets of transparency and accountability.

We thank you for the opportunity to review this final report and to provide comments to it.

Sincerely,

Juanita G. Gledhill
Chair

Attach.